# Authorization for Release of Information

*NOTE: COMPLETE ALL FIELDS TO ENSURE YOUR REQUEST CAN BE PROCESSED*

IHA ST. JOE'S MEDICAL GROUP

Office Location: _____

**I AUTHORIZE AND REQUEST the release of the specific information below for the patient listed here:**

**PATIENT NAME:** _____

LAST FIRST MI MAIDEN OR OTHER NAME DATE OF BIRTH SS#

**AUTHORIZED BY: (Patient, Parent or legal guardian) AND; I am authorized to make this disclosure:**

Name: _____ Date of Birth: _____ Phone# _____ Relationship: _____

Address: _____

**RELEASE FROM:**

Name: _____

Address: _____

Phone: _____ Fax: _____

**RELEASE RECORDS TO:**

Name: _____

Address: _____

Phone: _____ Fax: _____

**INFORMATION TO BE RELEASED:** *(Initial Below)*

Dates of service: _____/_____/_____ through _____/_____/_____

_____ Specifically my entire medical record **including**, Substance Abuse, Mental Health, HIV related testing;

_____ Specifically my entire medical record **excluding**, Substance Abuse, Mental Health, HIV related testing;

_____ Other: All relevant medical, inpatient, and diagnostic testing records or Specifically only _____.

**PURPOSE OF DISCLOSURE:**

☐ Relocating out of area ☐ Changing doctor in area ☐ Specialist Consultation/second opinion

☐ Transfer from pediatric to adult doctor ☐ Legal ☐ School ☐ Insurance Change (Non-par)

☐ Workers Compensation ☐ Medical Care ☐ Billing Information ☐ Other (please specify): _____

1. I understand that this authorization will expire 60 days **after I have signed the form**.
2. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. An exception for registered substance abuse and chemical dependency clients applies. See notice below.
3. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it. This authorization is in effect until it is revoked by me or until it expires under applicable laws.
4. An exception for registered chemical dependency and substance abuse patients who are involved in the Criminal Justice System when the consent is a condition of parole, probation or release from confinement applies. In these cases this consent may not be revoked at any time unless there has been a formal and effective termination or revocation of such release from confinement, probation or parole.
5. I understand signing this form is an option, my health care and payment for my health care will not be affected if I do not sign.
6. I understand that in compliance with the State of Michigan laws pertaining to record copies, I may be charged a reasonable cost based fee of $ _____.

_____ _____ OR _____ _____

SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

_____ _____ _____

RECORDS RECEIVED BY DATE RELATIONSHIP TO PATIENT

**INTERNAL USE**

**PRESENTED ID:** _____ **VERIFIED BY:** _____ **PROOF OF LEGAL GUARDIANSHIP:** _____

**PROVIDER REVIEWED:** _____ **DATE:** _____ **DATE REQUEST FILLED:** _____ **BY:** _____

**FEE COLLECTED:** _____ **WRITTEN REQUEST TO REVOKE (ATTACH) PROCESSED BY:** _____ **EFF DATE:** _____